West Seattle Orthodontics Heidi K. Horwitz, DDS

Dental History

Patient Dentist: Date of Last Visit:

1. Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No
2. Has the patient had or presently have any of the following habits?
   - ☐ Thumb or finger sucking ☐ Lip Biting ☐ Snoring
   - ☐ Grinding of teeth at night ☐ Mouth breathing ☐ No
3. Has the patient been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
4. Has an orthodontist been consulted previously? ☐ Yes ☐ No
   Name: Date:
5. Has the patient ever been treated for: ☐ Bad Bite ☐ TMJ ☐ Periodontal Disease ☐ No
   If so, by whom?
6. Does the patient have any speech problems? ☐ Yes ☐ No
7. Is there anything the patient would like to change about his/her smile? ☐ Yes ☐ No
   If so, what?
8. Has there ever been any orthodontic treatment for any siblings? ☐ Yes ☐ No
   Name: Doctor's Name:

Reason for consultation:

Medical History

Name of physician? Date of last physical:

1. Is the patient's general health good at this time? ☐ Yes ☐ No
2. Is the patient under the care of a physician at this time? ☐ Yes ☐ No
   If so, by whom?
3. Is the patient taking any medication? ☐ Yes ☐ No
   If so, please list?
4. Is the patient allergic to any medication (i.e. Penicillin, Sulfa, etc.)? ☐ Yes ☐ No
   If so, please list?
5. Has the patient had tonsils and adenoids removed? ☐ Yes ☐ No Date: ________________
6. Has the patient ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: ________________
   Explain
7. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ Yes ☐ No
   If yes, antibiotic name and method:
8. Has the patient reached puberty? ☐ Yes ☐ No
9. Is there any other information that should be known about your child's health?
   If so, please list?
10. Please check all conditions the patient has now or has ever had:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Endocarditis	☐	☐	Prosthetic (artificial joint)	☐	☐	Blood Disorders/Bleeding Problems	☐	☐	Liver Disease
☐	☐	Heart Condition	☐	☐	X-Ray/Radiation therapy	☐	☐	Inflammatory Rheumatism	☐	☐	Psychiatric Treatment
☐	☐	Heart Pacemaker	☐	☐	AIDS or H.I.V. Positive	☐	☐	Arthritis	☐	☐	Drug Addiction
☐	☐	Heart Angina	☐	☐	Diabetes	☐	☐	Ulcers	☐	☐	Headaches
☐	☐	Heart Attack (coronary)	☐	☐	Respiratory Lung Disease	☐	☐	Stroke	☐	☐	Earaches
☐	☐	Mitral Valve Prolapse	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐	Jaw Clicking
☐	☐	Congenital Heart Disease	☐	☐	Low Blood Pressure	☐	☐	Asthma	☐	☐	Allergies
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis (type?________)	☐	☐	Epilepsy	☐	☐	Jaw Pain
☐	☐	Heart Surgery date: _____	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐	Tonsillitis
☐	☐	Heart Murmur	☐	☐	Venereal Disease	☐	☐	Fainting Spells	☐	☐	Allergies to any metals
☐	☐	Rheumatic Fever	☐	☐	Herpes (oral-cold sores)	☐	☐	Kidney Trouble	☐	☐	Emotional Problems

☐ Other:

I certify that the information given is correct and give consent to Dr. Heidi K Horwitz, DDS to treat my child

Signature: Date:

(Please circle one) *Parent* *Guardian* *Other:* ____________________

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For office use only

Reviewed by:________________________________